UnumProvident

Reassessment Information Form

Mail to: UnumProvident Claim Reassessment Unit
PO Box xxx, Portland, ME 04104-5028

Claim Questions: 1-866-xxx-xxxx

Fax to: 1-866-xxx-xxxx

B. CLAIMANT'S EMPLOYMENT INFORMATION (PLEASE PRINT)

Name of Employer A.	Employer's Telephone Number
Dates of Employment	
Employer's Address (Street, City, State, Zip)	
Your occupation and work schedule with this employer	
Weekly or Monthly Earned Income Before Taxes $ (please provide documentation of earnings)	

Name of Employer B.	Employer's Telephone Number
Dates of Employment	
Employer's Address (Street, City, State, Zip)	
Your occupation and work schedule with this employer	
Weekly or Monthly Earned Income Before Taxes $ (please provide documentation of earnings)	

Name of Employer C.	Employer's Telephone Number
Dates of Employment	
Employer's Address (Street, City, State, Zip)	
Your occupation and work schedule with this employer	
Weekly or Monthly Earned Income Before Taxes $ (please provide documentation of earnings)	

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C. CLAIMANT'S MEDICAL INFORMATION (PLEASE PRINT)

Please provide full and complete responses, indicating "none" where applicable. If more space is needed, please attach lists as necessary.

1. Name(s) and complete address(es) of any medical care provider you consulted for any condition since your claim was closed.

Name of Doctor	Complete Address (Street, City, State, Zip)	Dates of Treatment	Telephone/Fax#

2. Indicate the name(s) and complete addresses of any hospital/clinic where you received medical treatment, consultation, care or services (including diagnostic measures) since your claim was closed.

Name of Hospital/Clinic Telephone/Fax#	Complete Address (Street, City, State, Zip)	Dates Treated

3. List any medications and prescribed drugs taken since your claim was closed.

Name of drug or medicine	Prescription Number	Pharmacy	Date	Physician

4. Please provide the complete address of any pharmacy listed in response to Question#3.

Name of Pharmacy	Complete Address(Street, City, State, Zip)	Telephone/Fax #

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D. CLAIMANT'S OTHER INCOME BENEFITS (PLEASE PRINT)

Check the other income benefits you have received, or are receiving, or are eligible to receive as a result of your disability and complete the information requested.

Please also report any changes to previously reported benefits.
If you have been approved or denied for any of these benefits, please send a copy of award or denial notification.

Social Security/Retirement ☐ Yes ☐ No	Social Security/Disability ☐ Yes ☐ No	Canada Pension Plan ☐ Yes ☐ No	State Disability ☐ Yes ☐ No
Workers' Compensation ☐ Yes ☐ No	Pension/Retirement ☐ Yes ☐ No	Pension/Disability ☐ Yes ☐ No	Unemployment ☐ Yes ☐ No
No-fault insurance ☐ Yes ☐ No	Short Term Disability ☐ Yes ☐ No – Ins. Co. Name and Policy #		
Other (include Individual Disability or Group Disability Benefits) ☐ Yes ☐ No – Ins. Co. Name and Policy #			

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Claim Fraud Warning Statements

For your protection, the laws of several states, including Alaska, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma, and others require the following statement to appear:

Fraud Warning

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud which is a felony.

Fraud Warning for California Residents

For your protection, California law requires the following to appear:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Fraud Warning for Colorado Residents

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete , or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning for District of Columbia, Maine, Tennessee and Virginia Residents

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Fraud Warning for Florida Residents

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of fraud in the third degree.

Fraud Statement for New Jersey, New Mexico, and Pennsylvania Residents

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Fraud Statement for New York Residents

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

E. The information which I have provided on this Reassessment Information Form is true and complete to the best of my knowledge and belief.

Signature _____ Date_____

Reassessment Information Form

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F. **Conditional Waiver and Release**

By choosing to participate in the Claim Reassessment Process, I hereby agree that if (and only if) the reassessment results in a reversal or other change in the prior decision denying or terminating benefits, I will not pursue any legal action to the extent (and only to the extent) such action is based on any aspect of the prior denial or termination that is reversed or changed. If I receive any additional benefits as a result of this reassessment, I hereby waive and release any right to sue UnumProvident Corporation, its insurance subsidiaries* and duly authorized representatives, for their prior failure to pay those same benefits to me. If I have already commenced legal action relating to my prior claim(s) decision, I will take such action as is necessary to stay such litigation pending the reassessment process, if the court will agree to such a stay, and I agree that if (and only if) the reassessment results in a reversal or other change in the prior decision denying or terminating benefits, then I will withdraw any litigated claim, including any extra-contractual claims, to the extent (and only to the extent) such claims are based on any aspect of the prior denial or termination that is reversed or changed. To the extent that following the reassessment there remains a complete or partial denial of benefits, my right to initiate or continue litigation regarding that portion of the prior denial that has not been reversed or changed is not waived. In addition, any applicable statute of limitations is tolled during the pendency of the reassessment of my claim; however, I understand that my participation in the Claim Reassessment Process will not revive or reinitiate the statute of limitations with respect to the previous claim decision.

This waiver and release will not apply to the extent that any prior decision is not reversed as a result of the Claim Reassessment Process.

Signature _____ Date_____

* This waiver and release is valid for the following UnumProvident subsidiaries: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, The Paul Revere Life Insurance Company.

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G. NOTE: Federal law requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, UnumProvident may not be able to evaluate or administer your claim(s). Please sign and return this authorization with the completed Reassessment Information Form.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer claims for UnumProvident Corporation, its insurance subsidiaries* and duly authorized representatives ("UnumProvident"). Information about my health may relate to any disorder of the immune system including but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes. I understand that information on financial or credit history or earnings will not be sought from an employer if it is not relevant to evaluating my claim(s) for benefits.

I understand that any information UnumProvident obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for benefits, which may include assisting me in returning to work. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever period is shorter. A photographic or electronic copy of this authorization is valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent UnumProvident has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, UnumProvident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the Company.

I understand if I do not sign this authorization or if I alter its content in any way, UnumProvident may not be able to evaluate or administer my claims(s) and this may be the basis for denying my claim(s).

Signature _____ Date_____

Print Name _____ Social Security Number _____

If signed on behalf of the claimant as personal representative, please indicate relationship here _____. If signed on behalf of the claimant as designee under power of attorney, as guardian, or as conservator, please attach a copy of the document granting authority.

* This authorization is valid for the following UnumProvident subsidiaries: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, The Paul Revere Life Insurance Company.

EXHIBIT 2

CHANGES IN CLAIM ORGANIZATION

Exhibit 2 is responsive to Paragraph B.3.a. of the Regulatory Settlement Agreement.

Current Organization

In the current organization of the Companies' claims operation the primary responsibility for making a claim decision rests with a Disability Benefit Specialist ("DBS") who generally receives guidance on a given claim from a Consultant who has more claim handling experience. The DBS also has access to additional internal resources, including nurses, physicians, vocational rehabilitation specialists, accountants and lawyers. The DBS's are in units that report to Managers and Directors, who have more claims handling experience but generally perform management roles and are not involved in individual claim files. Consultants generally do not have management responsibilities.

Changes in Claim Organization

In order to address areas of concern noted in the Multistate Examination Report and increase the effectiveness of the claims operation in processing claims, changes are being made to increase the claim handling experience of personnel involved at the earliest stage of reviewing a claim, add to the accountability for compliance and increase the involvement of higher level management in approving claim decisions. The primary changes are as follows:

1) The Consultant position is being eliminated, and the individuals serving in that position are being reassigned to various other positions, including DBS, Manager, newly created positions in the Claim Reassessment Unit, and the newly created Quality Compliance Consultant positions.

2) Individuals serving in the existing Manager positions will become more directly involved in daily activities and decisions associated with claims; will be directly accountable for claim decisions made in their unit; will ensure that appropriate actions are taken and information received on claims before a decision is made; and will be responsible for developing the technical expertise of the staff in their unit. Managers generally have at least five years of claim handling experience.

3) A new position, Quality Compliance Consultant ("QCC") will be created to focus upon compliance, documentation, accountability for compliance, issues of fairness to claimants, and avoidance of improper claim practices. The position description for QCC is set forth in Exhibit 3.

EXHIBIT 3

Position Title: **Quality Compliance Consultant**
Job Code: New role to organization
Job Level:
Exemption Status: Exempt

General Summary

This highest level technical position is directly responsible for ensuring quality (appropriate file documentation and decision rationale) and compliance. They are relied upon to provide guidance, training and direction to the Disability Benefits team with a strong partnership with Legal.

Principal Duties and Responsibilities

Claim Management

- Enhance organizational performance through ensuring quality of claim documentation and decision rationale
- Develop and build in-depth technical expertise in the Disability Benefits team
- Analyze and conduct needs assessment to assist with development of strategies to improve quality of performance
- Utilize and convey expertise in multiple product lines (STD, LTD, IDI)
- Mentor claims personnel
- Utilize appropriate resources, as needed, to arrive at thorough, fair and objective decisions
- Proactively review files to assess quality and compliance
- Ensure corporate and claimant compliance with ERISA standards, as applicable

Customer Service and Partnering

- Provide feedback to Disability Benefits Specialists, Managers, and Directors on quality of specific claim documentation and decision rationale
- Build and maintain partnerships with management team members and legal team
- Partner with Legal to provide quantitative and qualitative feedback on overall quality of claim documentation and decision rationale
- Partner with QPS (Appeals, Audit and Training) to identify trends and develop action plans to improve overall quality of claim management
- May perform other duties as assigned

Job Specifications

- Any combination of education or experience equivalent to ten years disability experience and/or seven years disability claims experience preferred

- Demonstrated success in managing highly complex claims
- Undergraduate degree required
- Strong preference for one or more Insurance Industry designations (ALHC, FLMI, ACS, etc.)
- Proven ability to successfully coach and mentor others
- Strong decision making and problem solving skills
- Ability to effectively and professionally interact/partner with internal and external representatives and resources
- Exceptional written and oral communications
- Superior analytical skills with an understanding of the functional requirements of the organization
- Demonstrated understanding of disability claim operations

EXHIBIT 4

IMPROVED PROCEDURES FOR EVALUATING MULTIPLE CONDITIONS OR CO-MORBID CONDITIONS

1. Guiding Principles (see also UnumProvident Clinical, Vocational, and Medical Services Statement Regarding Professional Conduct)

Benefit Center professionals will evaluate all data available regarding a claim
Both objective and subjective
Both supporting impairment and supporting capacity

Benefit Center professionals will consider and afford appropriate weight to all diagnoses and impairments, and their combined effect on the whole person, when evaluating medical data in a claim file.

Where multiple conditions or co-morbid conditions are present, each medical professional and all other Benefit Center professionals evaluating the claim share responsibility to ensure that all diagnoses and impairments are considered and afforded appropriate weight.

When multiple medical professionals review a file, each medical professional and all other Benefit Center professionals share responsibility for coordinating their opinions and ensuring that each understands how the various opinions fit together in a coherent view of the claimant's medical condition, capacity, and restrictions/limitations.

2. Changes in procedures

Several techniques will be used to ensure that claimants with multiple conditions are fully and fairly evaluated regarding the totality of their limitations. These alternatives include

- Designated clinical consultant in each impairment unit to receive and manage consultation requests from other units
- Access to multi-disciplinary meetings to consider totality of impairments
- Referral to generalist or primary care physician (internist, occupational physician, or family practitioner) to consider effects of all conditions on overall function and limitations

Each of these techniques is currently in use at two or more locations, and all locations
use at least two of these techniques.

A Medical Analysis Checklist (see format below) has been developed as a tool for Benefit Center professionals. The checklist should be used when multiple on-site physicians have reviewed a file, and is available as a tool for organizing a whole person analysis of impairments for any claimant.

3. Training

Clinical, Vocational, and Medical Directors at each claim processing location will identify areas for company-sponsored continuing nursing and physician education.

Medical Analysis Checklist

The checklist may be useful at several points during a claim, including liability determination, change of definition, and contemplated claim closure. It provides a "snapshot" at a particular point in time of all recent treaters, diagnoses/syndromes/problem areas identified, restrictions and limitations arising from each, and our contractual assessment of those restrictions and limitations.
For illustrative purposes only, an example is offered below on how the form might be used.

Claimant: Jeff Styles **Soc Sec #:** 345 - 67 - 8912 **Date:** 8 / 11 / 2004

Physicians Consulted In Last Year		**Diagnoses or Syndromes**	**Restriction Identified**	**Limitation Identified**	**Assessment**
Physician	**Date Last Seen**				
Thos. Moore, MD	7/9/04	1. Cardiomyopathy		Sedentary work only	Mr. Styles' insured occ as foreman required frequent walking; at change of def we have identified gainful sedentary positions in his region
			Must be able to elevate feet above chest 10" every		Voc reports this is an accommodation permitted by most employers, and confirmed by those

			hour		offering gainful positions
			No lifting over 10#		Available in gainful positions
		2. Atrial fibrillation	No work near microwaves or large electrical power sources due to implanted defibrillator	No lifting over 20#	Available in gainful positions
Roger Grise, PhD	6/7/04	3. Depression		Impairments in interpersonal relations; concentration; deep pessimism	Dr. Grise reports depressive symptoms have remitted; GAF now 72; limitations considered resolved per OSP assessment of 7/29/04; Dr. G agrees per letter of 8/4/04
James Fisher, MD	4/12/04	4. Fatigue	No prolonged standing or walking (>30"); requires variable schedule and up to 1 hr of rest per 4 hrs worked		Re-conditoning via PT improved endurance as of 7/29/04 per Dr. Liu
Frederick Liu, MD	5/7/04	5. Diabetes mellitus	Regular meals; no overtime; needs regular schedule		Gainful occupations permit regular hours
		6. Epilepsy			Never asserted as cause of disability; has been well controlled since 1993 by medication

		7. Chronic pain (fibromyalgia)		Cannot work more than 2 hrs daily	Through cog-behav program delivered through Dr. Grise, Mr. Styles has improved his conditioning and attitude and now reports he is ready for a gradual RTW. Dr. Liu concurs and will manage rehab program

EXHIBIT 5

UNUMPROVIDENT CLINICAL, VOCATIONAL, AND MEDICAL SERVICES STATEMENT REGARDING PROFESSIONAL CONDUCT

Dear Benefits Center Clinical, Vocational, or Medical Professional:

UnumProvident is committed to standards for the prompt, fair and reasonable evaluation and settlement of claims. As participants in the claims process we play an integral role in achieving these service standards and must be willing to subscribe to the Benefits Center Philosophy:

With a commitment to integrity, quality and superior service, we will:

- Make appropriate decisions by providing a thorough, fair and objective evaluation of all claims.
- Pay all valid claims in a timely manner with a high level of service.
- Partner with our customers in their efforts to return to work or to independent living.

The Benefits Center Philosophy cannot be fully realized without our full commitment to our professional ethical standards. Likewise, UnumProvident's commitment is that these standards not be compromised in the course of our work activities on its behalf. Ultimately, however, professional ethical conduct is an individual responsibility. The measure of our success is how we conduct ourselves each day.

Please review and retain the attached "UnumProvident Clinical, Vocational, and Medical Resource Statement Regarding Professional Conduct." I/we am/are confident in your commitment to conduct yourselves in accordance with these high standards.

Sincerely,

Chief Ethics Officer

UnumProvident Clinical, Vocational, and Medical Professionals' Statement Regarding Professional Conduct

Clinical, vocational, and medical professionals within the Benefits Center will:

- **Comply with all applicable laws, ethical codes, and standards of professional conduct.**
- **Communicate with partners and internal customers promptly and professionally.**

- **Discuss medical and/or vocational facts in an open and honest manner.**
- **Provide fair and reasonable evaluations considering all available medical and/or vocational evidence, both objective and subjective, both supporting impairment and supporting capacity.**
- **Consider all diagnoses and impairments, and their effect on the whole person, when evaluating medical and/or vocational data in a claim file.**
- **Work with or refer files to other appropriate medical personnel when specialization prevents one professional from considering all impairments and diagnoses in an evaluation of the whole person.**
- **Complete "Fair Claims Settlement Practice" training annually.**
- **Represent medical and/or vocational facts accurately.**
- **Provide reasonable, clear, and accurate explanations of professional opinions so that clear and full explanations of decisions based on those opinions are available to the claimant.**
- **Avoid redundant or unnecessary requests for information, e.g. duplicate information, data not reasonably required for adequate analysis, or data not material to the analysis of the claim.**
- **Report any significant barriers to achieving the Benefits Center Philosophy and its application to your management, directly to the company's Chief Ethics Officer or through the Business Practices & Ethics Hotline as outlined in UnumProvident's Code of Business Practices & Ethics.**

I have read and understand the principles and guidelines above. I agree to abide by these principles in my work on behalf of UnumProvident Corporation, and to consult with peers, managers, and ultimately the Chief Ethics Officer if I am unclear regarding my responsibilities under these principles or encounter barriers to abiding by them. In addition, prior to making each determination as to a claimant's impairment, for which I have been trained, I will certify that I have reviewed all medical, clinical, vocational and other evidence provided to me bearing upon impairment.

_____ _____

Name **Date**

EXHIBIT 6

GUIDELINES FOR INDEPENDENT MEDICAL EVALUATIONS

A. Attending Physician ("AP") Related. If a determination is made that the medical information in the claim file lacks clarity or sufficiency in assessing the insured's medical condition in order to validate the claim under the requirements of the applicable policy or if the Company has reason to question the opinions or information provided by a claimant's AP, the appropriate Company medical professional should contact the AP either by phone or by letter for clarification or additional information. If a telephone contact cannot be arranged, a letter outlining the question(s) and issues should be sent to the AP, which invites a reply either by phone or by letter.

Following such contact, if the Company's medical professional and the AP are unable to reach an agreement on the medical issue or issues and its or their effect on the claimant's capacity for work an independent medical evaluation should be sought under the following guidelines unless the decision is made to pay or continue to pay the claim:

1. An independent record review should be sought whenever the lack of agreement primarily concerns an issue of data interpretation, and therefore an examination of the claimant would not be useful to understand the allegedly impairing condition.
2. An independent medical examination ("IME") of the claimant should be sought whenever there is lack of agreement and the opinion of the Company's medical professionals involved in the claim file is the primary basis for the denial or termination of benefits unless the following conditions are satisfied in which instance an IME need not be sought, and the claim file is documented with regard to these conditions being satisfied:

   i. The Chief Medical Officer ("CMO") of the Company or one of the Company's certified medical specialists with the highest level credentials in the specialty field in the Company relating to the claim and designated by the CMO to perform such reviews ("DMO") has reviewed the specific claim, focusing particularly on the area or areas of disagreement between the AP and the Company's medical professionals involved in the claim file,

   ii. The CMO or the DMO reviewing the specific claim file performs his or her separate analysis of the issue or issues upon which there is disagreement, including any other information in the file deemed by the reviewing CMO or DMO to be relevant to the claim decision, and

   iii. The CMO or the DMO reviewing the specific claim file concludes that there is reasonable medical certainty supporting the position of the Company's medical professionals involved in the claim file and in disagreement with the AP, after having determined that the AP's opinion is not well supported by medically acceptable clinical or laboratory diagnostic techniques and is inconsistent with the other substantial evidence in the claim file.

If the CMO or the DMO reviewing the specific claim file is unable to reach the conclusion set forth in subparagraph 2.iii. above, then an IME should be performed.

If the CMO or DMO agree with the AP's opinion, there is agreement as to the current existence of a disabling condition and no IME is needed at the present time.

B. An IME (or in circumstances relating to an issue of data interpretation in which case an independent record review) should be sought whenever any of the following occurs unless the decision is made to pay or continue to pay the claim:

1. A prior IME found disabling limitations and the current impairment is based on the same limitations;
2. A Company medical professional or other Company resource, e.g., legal/compliance, Benefit Specialist responsible for the claim, states that an IME is needed;
3. There is a difference of opinion between two or more of the Company's medical professionals with respect to the existence of a disabling condition; or
4. The claimant or the AP requests an IME, either directly or through the claimant's representative.

C. An IME must be obtained and conducted on the basis of objective, professional criteria:

1. The Company shall select individuals to conduct IME's solely on the basis of objective, professional criteria, and without regard to results of previous IME's conducted by such individuals; and,

2. Neither the Company nor any of its officers or employees shall attempt to influence the impairment determinations of professionals conducting IME's.

EXHIBIT 7

PROOF OF LOSS—DISABILITY CLAIMS

Introduction: The Companies' disability contracts require claimants to file a completed claim form when they are making a claim for benefits. This completed claim form satisfies the claimant's initial obligation to provide proof of loss as discussed below. Thereafter, the Company and the claimant work together to expedite the identification, retrieval and review of all information necessary to validate the payment of benefits under the applicable policy. The following details the proof of loss process:

Initial Proof of Loss: As part of the claim submission process, the claimant must provide information concerning the impairing condition. This information includes:

Claim forms, medical records, letters from physicians and other sources
Employment records, tax records and other professional records

Ongoing Proof of Loss: Once initial information is provided, the claimant has a legal obligation to cooperate with the Company's efforts to obtain any material information needed to assess the claim on an ongoing basis.

Company's Obligation to Verify and Validate: When a claimant submits a claim, the Company must first verify that the claimant is eligible for coverage under the applicable policy(ies). The Company also must validate the nature of the impairment and how it limits or restricts the claimant from engaging in his or her occupation. The Company's obligation may be fulfilled by seeking additional information, which can include:

Additional medical records and/or tests
Financial records for purposes of determining income loss and benefit levels
Records related to employment as well as occupational duties
Other lawful methods of information-gathering that assist in validating the claim

The Company is entitled to request a written authorization from the claimant in order to obtain additional medical or other information. The Company has an obligation to use such authorization to seek needed information at its own expense. The claimant is obliged to cooperate by providing information or documents in his or her possession and by otherwise participating in the claim investigation (e.g. attendance at an Independent Medical Examination.)

Communications with the Claimant: Throughout the claim administration process, the Company must alert the claimant as to any information or documents which are needed to pay benefits under the applicable policy.

Independent Medical Examinations and testing: In some instances, it may be appropriate for the Company to invoke its contractual right to request that the claimant

submit to an Independent Medical Examination, which may include additional medical tests. Specific guidelines for such Examinations are set forth in Exhibit 6.

Claim Handling Decisions: After the Company has made a good faith effort to obtain all material information necessary to make an informed claim decision, the information is analyzed and weighed in a fair and balanced manner. If the Company has sufficient evidence to validate the payment of benefits under the applicable policy's requirements, the claim will be paid.